STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. Survey dates: June 12, 13, 14, 17, 18, and 19, 2024 Facility number: 011045 Provider number: 155698 AIM number: 200380790 Census Bed Type: SNF/NF: 26 SNF: 34 Residential: 46 Total: 106 Census Payor Type: Medicare: 25 Medicaid: 25 Other: 10 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 25, 2024.	F 0000		
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Alicia Lambert | Executive Director | 07/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to properly monitor the use of oxygen, maintain oxygen equipment, and follow physician orders for oxygen therapy for 1 of 3 residents reviewed for respiratory care. (Resident 5) Finding includes: During an observation on 6/12/24 at 11:17 a.m., Resident 5 was in bed asleep with oxygen on via nasal cannula. The nasal cannula was connected to the oxygen concentrator and set at four liters per minute. The humidification canister, dated 5/25/24, was below the low line on the canister with no bubbling for humidification due to the low level. When the resident awoke, he indicated he was not feeling well and the nurse was aware. During an observation on 6/13/24 at 12:12 p.m., the resident was asleep in bed with his oxygen on via nasal cannula. The nasal cannula was connected to the oxygen concentrator and set at four liters per minute. The humidification canister, dated 5/25/24, was empty. During an interview on 6/13/24 at 12:16 p.m., the resident was in bed, lethargic, with his oxygen on via nasal cannula at four liters per minute. During an interview at the same time, RN 3 indicated the resident's humidification canister was dated 5/25/24, oxygen set a four liters, and he was not receiving humidification because the canister was empty. The canister should be kept full and was required to be changed monthly or as needed to ensure the resident's humidification was maintained.	F 0695	The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 Resident 5 was affected by alleged insufficient practice. Resident 5 continues to reside on the long term care unit of health campus. Following alleged insufficient practice, resident 5 orders were updated and no adverse effects noted. 2 All residents with orders for oxygen have the potential to be affected by the alleged insufficient practice. All residents oxygen orders reviewed and updated as	07/03/2024

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	Resident 5's clinical record was reviewed on 6/13/24 at 4:55 p.m. Diagnoses included, chronic obstructive pulmonary disease (COPD), pneumonia, heart failure and ischemic cardiomyopathy. A physician order, dated 2/21/23, indicated continuous oxygen at two liters per minute via nasal cannula, may titrate to maintain oxygen saturation above 92%. This order was discontinued on 6/14/24. A physician order, dated 6/14/24, indicated continuous oxygen at three liters per minute via nasal cannula, may titrate to maintain oxygen saturation above 92%. A current physician's order, dated 6/15/24, indicated continuous oxygen at four liters per minute via nasal cannula, may titrate to maintain oxygen saturation above 92 %. A current physician's order, dated 6/14/24, indicated doxycycline hyclate (antibiotic) 100 milligram (mg) capsule by mouth twice daily. A quarterly Minimum Data Set assessment, dated 3/11/24, indicated the resident had severe cognitive impairment. He required maximal staff assistance for toileting, dressing, hygiene, and mobility. A current care plan, last reviewed on 3/13/24, indicated the resident was at risk for potential complications related to congestive heart failure. Interventions included the following: administer oxygen per the physician order (12/22/21) and observe for and report complications as needed (12/22/21)		indicated per physician orders. All clinical staff educated on the monitoring oxygen use, maintaining oxygen equipment, and following physician orders for oxygen therapy. 3 As a measure of ongoing compliance, the DHS or designee to complete house wide audit on all residents for accurate oxygen orders by 7/3/24. DHS or designee will also audit 5 residents with oxygen for proper equipment 2 times per day for 2 weeks, then daily for 2 weeks, then 3 times a week for 3 months, then 2 times a week for 2 months, or until 100% compliance is maintained. 4 As a quality measure, Executive Director or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	A current care plan, last reviewed on 3/13/24, indicated the resident was at risk for potential complications related to COPD. Interventions included the following: administer oxygen per physician orders (12/22/21), monitor the oxygen saturation via pulse oximetry as ordered (12/22/21), and observe and report signs of respiratory distress (12/22/21). The clinical record lacked any provider notification of an increased need for oxygen titration on 6/12/24 and 6/13/24. A nurse's noted, dated 6/14/24 at 10:45 p.m., indicated the resident received treatment for pneumonia. During an observation on 6/17/24 at 2:39 p.m., the resident was seated in a wheelchair in his room. The left prong of the nasal cannula was in his right nare and the right prong of the nasal cannula to the right side of his nose. The resident was lethargic. The oxygen concentrator was turned off and the nasal cannula was connected to his portable oxygen tank, hung on the back of his wheelchair. The gauge of the tank indicated the portable oxygen tank was empty. During an interview at the time of observation on 6/17/24 at 2:40 p.m., RN 4 indicated the resident's nasal cannula was connected to an empty portable oxygen concentrator on the back of his wheelchair, so the resident was not receiving any oxygen. She turned on the concentrator and set the oxygen at three liters per minute and applied the nasal cannula to both nares. She indicated she needed to obtain the pulse oximeter, and returned to the resident's room at 2:42 p.m. When assessed, the resident's oxygen saturation was 89			

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	%. She exited the room to check the resident's oxygen order, returned, and indicated that it was continuous oxygen via nasal cannula at four liters per minute. She entered back into the resident's room at 2:43 p.m. and adjusted the concentrator to four liters per minute. The resident's oxygen saturation was 92 % upon re-assessment. During an interview on 6/17/24 at 2:45 p.m., RN 4 indicated the resident's nasal cannula should have been connected to the oxygen concentrator when the resident was in their room. A portable oxygen tank did not last very long when a resident received four liters of oxygen per minute. During an interview on 6/17/24 at 3:20 p.m., CNA 8 indicated portable oxygen tanks should have been refilled to ensure the resident did not run out of oxygen. The resident was dependent on staff to manage and monitor the resident's continuous oxygen. Staff were required to fill the portable tanks when the residents were taken out of their room. The resident should have been placed back onto to his oxygen concentrator to ensure the portable tank did not run out. During an interview on 6/18/24 at 2:24 p.m., the Corporate Nurse Consultant indicated oxygen humidity should be used based on the order. Physician orders for continuous oxygen should have been followed to ensure a resident did not run out of oxygen. Residents on portable tanks should have been switched over to the oxygen concentrator when they were brought back to their room to avoid a lack of continuous oxygen. During an interview on 6/18/24 at 2:39 p.m., the Corporate Nurse Consultant indicated oxygen humidification was used for orders of oxygen at four liters per minute and as needed. Nurse's were			

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	expected to use nursing judgement regarding the oxygen orders that lacked a specific parameter for titration. Residents with COPD may not be appropriate for oxygen to be titrated higher than 2-3 liters per minute. The nurses should have notified the physician each time there was a need for them to titrate a resident's oxygen because this was considered a change in condition. During an interview on 6/19/24 at 9:29 a.m., LPN 7 indicated she thought oxygen orders with titration to maintain specific oxygen saturations could be titrated as high as 6 liters per minute. Oxygen orders should have included how high the oxygen could have been titrated. During an interview on 6/19/24 at 9:33 a.m., LPN 5 indicated oxygen could have been titrated as high as 5 liters per minute. If an oxygen order did not include a range for titration, then the physician should have been notified to obtain parameters because each resident had different requirements for oxygen based on their diagnoses. A current facility policy, dated 12/31/23, titled "Respiratory Equipment," provided by the Administrator on 6/17/24 at 4:58 p.m., indicated the following: "...SOP [standard operating procedure] DETAILS... 1. The following equipment and supplies will be necessary when performing this procedure. a. Appropriate equipment/supplies necessary for ordered therapy... 2. Oxygen Administration... c. May use prefilled disposable humidifier bottles... h. Change prefilled humidifier when water level becomes low...." A current facility policy, dated 12/31/23, titled "Guidelines for Medication Orders," provided by the Administrator on 6/17/24 at 4:58 p.m.,			

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	indicated the following: "...PURPOSE... To establish uniform guidelines in the receiving and recording of medication orders. PROCEDURES... 6. Oxygen orders a. When recording oxygen orders specify: 1. The rate of flow, route and rationale (i.e.: O2, 2 L/min per nasal cannula PRN [as needed] for SOB [shortness of breath] ...." 3.1-47(a)(6)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based in observation, interview, and record review, the facility failed to offer dementia services for residents residing on a dementia unit to enhance quality of life regarding sensory items and purposeful activities for 4 of 4 residents reviewed for dementia services (Resident 19, 17, 10, and 34). Findings include: During a confidential interview an employee indicated the staff had been concerned about the lack of meaningful and purposeful activities and events on the dementia care unit. During an interview on 6/17/24 at 10:24 a.m., LPN 5, who was the charge nurse on the dementia unit, indicated she did not know who the dementia unit director was. She indicated she had herself had training to be a "Legacy Leader", which was a leadership role on the unit.	F 0744	The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the	07/03/2024

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	During observations of the special care dementia unit on 6/12/24, 6/13/24, 6/17/24, and 6/18/24 the following concerns regarding meaningful programing, offering a stimulating environment, and purpose activities at the residents cognitive levels were made: During an observation on 6/12/24 at 11:10 a.m., nine residents were seated at the long dining table located in the conjoined TV lounge/dining activity unit. The residents were facing the table as if prepared to dine. The residents did not have sensory materials, such as books, magazines, puzzles, games, art materials, and/or manipulative devices. A staff member did not interact with the residents or offer conversation. The residents sat in this area from 11:10 a.m. to 11:30 a.m. facing the table without being offered a sensory materials and/or a purposeful or meaningful pursuit. At 11:10 a.m., Resident 17 was seated in a wheelchair. His eyes were closed. He was leaning to the left. At 11:10 a.m.,. Resident 34 was moving restlessly and rubbed another resident's back. A staff member moved him in his wheelchair farther down the table. At 11:10 a.m., Resident 10 sat at the table with her eyes closed and her head back. At 11:10 a.m., Resident 19 sat in his wheelchair at the table facing forward and looking straight ahead. At 11:30 a.m., Resident 34 attempted to stand and was instructed to sit down by a staff member. During this time residents did not interact with		department a desk review for substantial compliance. 1 Resident 19, 17, 10, and 34 were affected by alleged insufficient practice. Resident 19, 17, 10, and 34 reside on health center memory care unit of health campus. No adverse effects noted on any resident listed. 2 All resident residing on health center memory care unit have the potential to be affected by the alleged insufficient practice. All life enrichment and legacy staff educated on the daily rhythm activity programming and use of sensory items. 3 As a measure of ongoing compliance, the Life Enrichment Director, or designee to complete audits for purposeful activities and the use of sensory items five times a week for 2 months, then three times a week for 2 months, then two times a week for 2 months, or until 100% compliance is maintained. 4 As a quality measure, Executive Director or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	each other, staff, or their environment. At no time on 6/12/24 were the staff observed offering any sensory materials, such as books, magazines, puzzles, games, art materials, and/or manipulative devices to the residents. Although some supplies sat on top of a cabinet, sensory items where not placed in common areas for residents to obtain themselves during the observations. During an observation on 6/13/24 from 9:47 a.m. to 10:10 a.m., a small group of residents were seated in a circle in the TV area on the dementia unit. Activity Assistant 9 was speaking with the residents. Present in the circle were Resident 17, Resident 34, Resident 10, and Resident 19. Activity Assistant 9 read to the residents about receiving and sending a message in a bottle. She told a story about receiving a bottle with a message and writing a reply to the sender. She asked lengthy questions which required multiple word responses. She asked questions which required abstract reasoning, such as what do you think is the most important thing we should tell the sender? She did not restructure questions to adjust for dementia and severe cognitive impairment. Residents did not answer the questions. She did not have any visual or tactile devices to fit the them. The residents had nothing to touch or observe in conjunction with the message in a bottle activity. Occasionally another resident, who was very verbal, did talk. He did not answer the asked questions. Residents in attendance looked around, closed their eyes, touched the floor, sat with their head titled far forward resting their chin on their chest. The residents did not activity participate in the activity. The residents did not passively participate and observe the event.			

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	During an observation on 61/13/24 from 10:14 a.m. to 10:59 a.m., the following food related activity was offered. At 10:14 a.m., Activity Assistant 9 began reading a recipe and talking about cooking. By 10:22 a.m., a group of residents was escorted to the dining room table for a cooking activity. Residents, 19, 17, 10, and 34 were in the group of residents. From 10:22 a.m. to 10: 57 a.m., (35 minutes) the residents sat at the table awaiting the cooking activity. No sensory or diversionary materials were provided during the 35 minute wait. During the 35 minute wait, Activity Assistant 9 left the area multiple times to get ingredient and cooking supplies. At 10:49 a.m., Activity Assistant 9 indicated she need to leave the area once again to get parchment paper. At 10:57 a.m., Activity Assistant 9 stated "We can officially get started." During the 35 minutes of waiting Resident 34 pushed himself away from the table multiple times and was pushed back to the table by direct care staff. At 10:59 a.m., (37 minutes after they were seated at the table) Activity Assistant 9 began to ask and assist residents to add ingredients to a bowl. At no time on 6/13/24 were the staff observed offering any sensory materials, such as books, magazines, puzzles, games, art materials, and/or manipulative devices to the residents. Although some supplies sat on top of a cabinet, sensory items where not placed in common areas for residents to obtain by themselves during the observations. During an observation on 6/17/24 from 9:30 a.m., to 9:56 a.m., a balloon and landmark activity was observed. At 9:30 a.m., Residents 19, 17, and 34 were involved in a game of balloon ball. All three residents were attempting to participate in the ball			

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	game. At 9:35 a.m., Activity Assistant 9 indicated balloon ball was over and it was time to begin another event. At 9:37 a.m., Activity Assistant 9 began to read to the three residents about landmarks. Residents 19, 17, and 34, who had been activity attempting balloon ball, did not reply to questions. Residents 19 and 17 closed their eyes and stopped interacting. By 9:39 a.m., Resident 10 had been escorted to join the group. Shortly after joining the group, Resident 10 closed her eyes. Activity Assistant 9 began to show the residents photos on a iPad device. The iPad device was approximately 8 inches by 10 inches. She moved the iPad from resident to resident. She held the iPad from 10 inches to 2 feet from the resident. She asked questions that required abstract thought and reasoning, such as, Do you know what this landmark is named and/or where it is? She did not adjust the questions for cognitive limitations. There were no tactile or sensory materials to compliment the activities. Another resident repeated words she said. He did not converse on topic. Residents 19, 17, 10, and 34 did not activity participate in the activity, nor did the residents passively observe the activity by watching the event. During an observation on 9/17/24 from 9:57 a.m. to 10:08 a.m., Activity Assistant 9 read local news aloud. As she read the news, one resident looked at her. One restless resident, Resident 17, held her hand. No residents asked or answered questions during the news paper reading. The residents did not show signs of either active or passive participation. During an observation on 9/17/24 at 10:08 a.m., Residents were escorted to the large table in the adjoined dining area. The Activity Assistant indicated we will talk about what you all would			

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	like for Happy Hour Snacks. A group of residents which included Residents 19, 17, 10 and 34 were moved to the table. They were all seated at the table as if awaiting a meal. Activity Assistant 9 indicated she needed ingredient to make cookies and left the area. She went to the adjoined kitchen and looked in cabinets as the residents sat at the table. At 10:15 a.m., the activity assistant offered the residents some chocolate chips. Residents were offered fluids by direct care staff. At 10:19 a.m., Activity Assistant 9 indicated she would get a piece of paper then they could "get to business." She said they could put cookies together while writing their snack list. She then began asking what snacks the residents liked. The residents did not answer. She did not ask yes or no questions, she repeated the question, what do you like. At about 7 minutes without answers, she began listed food and asking if they liked it. One talkative resident responded. Residents 19, 17, 10 and 34 did not participate in the conversation. At 10:22 a.m., she began to place ingredients in measuring cups and ask residents if they'd like to pour the item into the mixing bowl. After asking three residents, who did not pour the items in the bowl, she poured all the ingredients in herself. The residents did not watch the food preparation. Residents 19, 17, 10, and 34 alternated between restless movement, looking about, and sitting with their eyes closed and head down. At 10:34 a.m., the activity assistant was again talking about Happy Hour snacks. She talked about snacks with only one resident responding until 10:47 a.m. On 6/17/24 from 1:39 p.m. to 2:52 p.m., (1 hour and 13 minutes), no structured activities were offered on the unit. At 1:51 p.m., LPN 5 attempted to adjust the TV to a program for the residents to watch. She made some phone calls for assistance.			

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	At 1:58 p.m., the TV was working and turned to The Beverly Hillbillies. Resident 34 did watch the TV. No other residents participated in TV viewing. At no time on 6/17/24 were the staff observed offering any sensory materials, such as books, magazines, puzzles, games, art materials, and/or manipulative devices to the residents. Although some supplies sat on top of a cabinet, sensory items where not placed in common areas for residents to obtain by themselves during the observations. During an observation on 6/18/14 from 9:08 a.m. to 9:30 a.m., the following was noted: At 9:09 a.m., Resident 19 was escorted to the TV/Lounge area. At 9:14 a.m., two residents were in the TV area and Activity Assistant 9 began a breathing exercise activity. She began the event by reading a lengthy explanation of how deep breathing can benefit an individual. She read about stress reduction and respiratory function. She did not modify or adjust the information to meet the residents cognitive functioning levels. She asked the residents to place their right hands on their chest and left hand on their belly. She did not assist the residents to place their hands on their chest or belly, nor identify right and left. At 9:16 a.m., a nurse entered the area and assisted the residents to identify their right and left and place their hands in the correct locations. Resident 19 was offered assistance with hand placement. None of the residents in attendance took a deep breath or exhaled slowly when instructed. At 9:23 a.m., the Activity Assistant attempted some modification to the breathing exercise and told residents they did not need to use their hands, they would just breath in and out. At 9:26 a.m.,			

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	Resident 10 was taken to join the breathing activity. None of the residents were taking deep breaths and exhaling when instructed. This event ended at 9:30 a.m. Although they did leave their hands on the chest or belly for a few moments, when placed their by staff, no resident actively participated in the activity. The residents did not passively participate by watching the activity assistant who was demonstrating deep breathing. During an observation on 6/18/24 at 9:30 a.m., Activity Assistant 9 began to open multiple drawers looking through each drawer as if searching for an item. While she looked, she spoke to residents about a matching game. At 9:32 a.m., the Activity Assistant placed approximately 36 cards face down on a 3 foot wide circular table. The cards were large playing cards of approximately 3 inches by 5 inches in size. Residents were placed around the table. Residents 19 and 10 were in attendance. The activity assistant instructed the residents to flip over two cards and try to find a match. The first resident chose two Jacks; one Jack of diamonds and one Jack of clubs. The activity assistant indicated it was close but not the same suit so it wasn't a match. During this time she indicated she was not very familiar with cards. Until 9:45 a.m., residents tried to reach cards only being able to touch one or two cars in front of them. The cards placed down in the center were out of reach approximately two feet from the resident. There continued to be 36 cards to remember and choose. At 9:45 a.m., Activity Assistant 9 indicated there had been zero matches thus far. She indicated the residents were playing with a standard deck of playing cards. She then indicated she was unaware that there was only on card of each value in each suit, she had not been aware there was no way for a match to occur.			

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	During an interview on 6/18/24 at 9:47 a.m., Activity Assistant 9 indicated she had not had the needed matching pieces for the scheduled matching event and she had used a deck of playing cards as a substitute. The activities she offered were from the facility's "Life Loop" computer app. She was supposed to stick to the list. Even if residents were actively involved in something they liked such as balloon ball, she was supposed to stick to the list and move on. She was unsure how she would modify the activities to meet the resident needs and cognitive status. During an observation 6/18/24 at 9:59 a.m., the residents were escorted to the table and sat in a manner as if ready to dine. The Activity Assistant indicated they would make biscuits soon but she needed to get the supplies. Residents 19, 17, 10, and 34 were seated at the table. The activity assistant did not have her supplies gathered for the cooking event. She was away from the unit from 9:59 a.m. until after 10:10 a.m., when she was seen standing outside the main kitchen. At no time on 6/18/24 were the staff observed offering any sensory materials, such as books, magazines, puzzles, games, art materials, and/or manipulative devices to the residents. Although some supplies sat on top of a cabinet, sensory items where not placed in common areas for residents to obtain by themselves during the observations. During an interview on 6/18/24 at 10:02 a.m., LPN 5, who was the Legacy Leader /charge nurse on the dementia unit, indicated the majority of the residents on the unit no longer could identify their right from their left, required simple instructions			

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	and directions, could not usually reach an item placed two feet in front of them, and could not keep track of 36 matching items. The round table in the TV area was not a good choice for activities due to its lower height and size. Some of the residents were very hard of hearing and visually impaired and those issues should be considered when interacting with the residents. During an interview on 6/18/24 at 10:11 a.m., the Administrator, who also served as the Dementia Unit Director, indicated the program on the dementia unit should establish a daily rhythm for the residents. There was a calendar and "Life Loop" was also a computer program. She did not know if residents who were severely cognitively impaired could match 34 to 36 cards during a memory game. She did not know if the current residents could identify their right and left. The program should be followed to keep the daily rhythm even if residents were actively involved and enjoying and event. She was unsure what was meant regarding modifying or adjusting offered activities based on resident participation and cognition. There was a Legacy Leader on the unit to offer guidance and direction. 1. Resident 10's clinical record was reviewed on 6/13/24 at 3:31 p.m. Current diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, anxiety, and cognitive communication deficit. The resident had a current 6/2024 physician's order to reside on a secured dementia care unit. This order originated 5/2/23. A, 5/5/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and had visual impairment.			

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	An, 11/3/23, annual MDS assessment indicated used a wheelchair for mobility and her responsible party believed it was very important for the resident to enjoy her favorite music, to be up to day on the news, to be activity involved with groups of people, to be involved in her favorite activities, and to be involved in religious activities. The resident had a current, 5/13/24, care plan problem/need regarding the need to engage in meaningful activities. The resident had a current, 5/13/24, care plan problem/need regarding limited verbal communication. Approaches to this problem included ask yes and no questions to clarify. The resident had a current, 5/13/24,care plan problem/need regarding impaired cognition and short term memory impairment. Approaches to this problem included assess the degree of hearing ability and encourage to participate in activities of enjoyment. The resident had a current, 5/13/24, care plan problem/need regarding hearing loss. The resident had a current, 5/13/24, care plan problem/need regarding visual impairment. The resident had a current, 5/13/24, care plan problem/need regarding a significant severe cognitive deficits. Approaches to this problem included ask yes and no questions, encourage reminiscing, and reorient resident to activity and task as needed. 2. Resident 17's clinical record was reviewed on 6/13/24 at 2:56 p.m. Current diagnoses included			

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	Alzheimer's disease and dementia in other diseases classified elsewhere with behavioral disturbance. The resident had a current 6/2024 physician's order to reside on a secured dementia care unit. This order originated 12/1/21. A 5/16/24, quarterly, MDS assessment indicated the resident was severely cognitively impaired and had moderately impaired vision and hearing. A 2/14/24, significant change, MDS assessment indicated the resident's responsible party believed it was very important for him to be in group activities and he used a wheelchair for mobility. The resident had a current, 5/28/24, care plan problem/need regarding a sever cognitive deficit. Approaches to this problem included ask resident yes or no questions encourage reminiscing activities. The resident had a current, 5/28/24, care plan problem/need regarding the importance of engaging in activities. The resident had a current, 5/28/24, care plan problem/need regarding impaired cognition and short term memory impairment. Approaches to this problem included to assess hearing and visual ability and encourage participation in activities of enjoyment. 3. Resident 34's clinical record was reviewed on 6/13/24 at 3:06 p.m. Current diagnoses included frontotemporal neurocognitive disorder and delusional disorders. The resident had a current 6/2024 physician's order to reside on a secured dementia care unit. This order originated 3/18/24. A 5/8/24, quarterly, MDS assessment indicated			

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	the resident was severely cognitively impaired. A 10/19/23, annual MDS assessment indicated the resident used a wheelchair for mobility, and his family believed going outside in the fresh air was very important to him. The resident had a current, 5/17/24, care plan problem/need regarding long term memory loss. The resident had a current, 5/17/24, care plan problem/need regarding impaired decision making. Approaches to this problem included simplify tasks, segment steps or tasks, offer step by step instructions. The resident had a current, 5/17/24, care plan problem/need regarding cognitive impairment and short term memory loss. Approaches to this problem included assess hearing and visual functioning and encourage participation in activities. The resident had a current, 5/17/24, care plan problem/need regarding severe cognitive impairment. Approaches to this problem included encourage reminiscing activities, encourage resident to make simple decisions, ask yes/no questions, and reorient resident to activity and task. 4. Resident 19's clinical record was reviewed on 6/13/24 at 2:53 p.m. Current diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. The resident had a current 6/2024 physician's order to reside on a secured dementia care unit. This order originated 9/15/20. A 4/29/24, quarterly, MDS assessment indicated			

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	the resident was severely cognitively impaired and had moderately impaired vision and hearing. A 1/2/24, annual, MDS assessment indicated the resident believed it was very important to hear news and go outside for fresh air. He used a wheelchair for mobility. The resident had a current, 4/23/24, care plan problem/need regarding the need to engage in meaningful activities. The resident had a current, 4/23/24, care plan problem/need regarding impaired cognition and short term memory impairment. Approaches to this problem included assess hearing and visual ability, and encourage participation in activities. The resident had a current, 4/23/24, care plan problem/need regarding short term memory impairment. Approaches to this problem included encourage participation in activities The resident had a current, 4/23/24, care plan problem/need regarding limited verbal communication. Approaches to this problem included ask yes or no questions. The resident had a current, 4/23/24, care plan problem/need regarding the need to reside on a secured dementia unit. Approaches to this problem included encourage involvement in daily programming. An "Alzheimer's/ Dementia Special Care Unit" State Form 48896, completed by the facility and submitted on 12/12/23, indicated the following: "...Type of Training Required or Provided... Alzheimer's disease, dementia, stages of disease... Create an appropriate and safe environment...			

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	Techniques for communication... Using activities to improve quality of life... Which of the following therapeutic methods are used in the program/unit? Art Therapy... Exercise... Recreational therapy... Music therapy... Message ... Pet Therapy... Reminiscence therapy...." The June 2024 Legacy Lane activity calendar , provided by the Administrator on 6/18/24 at 12:06 p.m., indicated dementia unit activities should be offered in the following categories: Artisans, Circle of Friends, Community Connections, Creative Cooking, Daily Rhythm, Expressive Arts, Gathering of Friends, Generations, Group Games, Inspirations, Just the Guys, Keeping is Sharp/reminisce, Life Long Learning, Mindful Movements, Music to my Ears, Out and About, Signature Events, and Vitality. An undated, facility policy title, "Legacy Lane LEA Hours Guide", provided by the Administrator in 6/18/24 at 12:06 p.m., indicated the following: "...Objective: Life Enrichment team member dedicated to leading Daily Rhythms 4 hours/day, 7 days a week on Legacy lanes.... Benefits...increase Resident engagement and improve family satisfaction...." 3.1-37(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000		

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	State Licensure Survey. Survey dates: June 12, 13, 14, 17, 18, and 19, 2024 Facility number: 011045 Residential Census: 46 Bethany Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed June 25, 2024.			